

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

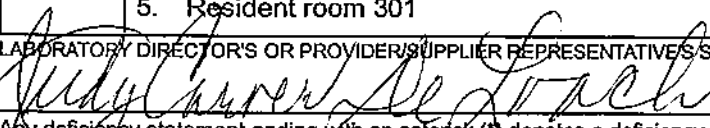
PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

450 4/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445469	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING A B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2014
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NAME OF PROVIDER OR SUPPLIER IVY HALL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 301 WATAUGA AVE ELIZABETHTON, TN 37643
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure corridor doors closed to a positive latch.</p> <p>The findings include:</p> <p>Observation on March 10, 2014 at 12:40 p.m. revealed the following doors did not close to a positive latch:</p> <ol style="list-style-type: none"> 1. Resident room 207 2. Resident room 201 3. Resident room 202 4. Resident room 303 5. Resident room 301 	K 018	<p>K018</p> <p>Ivy Hall Nursing Home believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Area</u></p> <p>On 3/17/14, the Maintenance Director repaired resident room doors 207, 201, 202, 303, 301, and 304 so they would close to a positive latch.</p> <p><u>Identification of Other Areas with Potential to be Affected</u></p> <p>On 3/25/14, the Maintenance Director inspected corridor doors and found no other areas to be affected.</p> <p><u>Systematic Changes</u></p> <p>The Maintenance Director will conduct a monthly audit to ensure that corridor doors latch to a positive latch.</p> <p><u>Monitoring</u></p> <p>The Maintenance Director will report his findings monthly to the Performance Improvement Committee for review and to determine ongoing compliance. The Performance Committee consists of the Administrator, Assistant Administrator,</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 3-28-14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 6. Resident room 304 These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on March 10.	K 018	Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, Maintenance Director, Dietary Manager, Housekeeping /Laundry Director, Activities Director, Medical Records Director, Human Resource Manager, MDS Coordinator, Medical Director, and Consultant Pharmacist.	3/25/14	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to have self-closing doors in hazardous areas. The findings include: Observation on March 10, 2014 at 12:00 p.m. revealed that the house keeping storage room and the general storage room in the employee lounge in the A Building are not self-closing and are over 50 square feet with combustible storage. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on March 10, 2014.	K 029	K029 Ivy Hall Nursing Home believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Area</u> On 3/18/14, the Maintenance Director installed door closers on the housekeeping storage and general storage doors in the employee lounge located in "A" Building. <u>Identification of Other Areas with Potential to be Affected</u> On 3/25/14, the Maintenance Director audited storage areas over 50 square feet in the facility and found no other areas had been affected.		

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to have self-closing doors in hazardous areas. The findings include: Observation on March 10, 2014 at 12:00 p.m. revealed that the house keeping storage room and the general storage room in the employee lounge in the A Building are not self-closing and are over 50 square feet with combustible storage. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on March 10, 2014.	K 029	<u>Systematic Changes</u> The Maintenance Director will conduct a quarterly audit of the facility so that storage areas that are greater than 50 square feet with combustibles have had a self-closing door installed. <u>Monitoring</u> The Maintenance Director will report his findings quarterly to the Performance Improvement Committee for review and to determine ongoing compliance. The Performance Committee consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, Maintenance Director, Dietary Manager, Housekeeping /Laundry Director, Activities Director, Medical Records Director, Human Resource Manager, MDS Coordinator, Medical Director, and Consultant Pharmacist.	3/25/14	

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K 066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to provide metal containers with self-closing lids to all smoking areas for ashtrays to be emptied into.</p> <p>The findings include: Observation on March 10, 2014 at 12:10 p.m. revealed that the A Building front entrance smoking area is not provided with metal</p>	K 066	<p><u>K066</u></p> <p>Ivy Hall Nursing Home believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p> <p><u>Corrective Actions for Targeted Area</u></p> <p>On 3/17/14, the Maintenance Director installed a metal container with a self-closing cover into which ashtrays located at "A" Building's front entrance smoking area can be emptied.</p> <p><u>Identification of Other Areas with Potential to be Affected</u></p> <p>On 3/18/14, the Maintenance Director inspected other designated smoking areas and found no other areas to be affected.</p> <p><u>Systematic Changes</u></p> <p>The Maintenance Director will inspect designated smoking areas monthly to ensure proper placement of self-closing metal ash containers.</p> <p><u>Identification of Other Areas with Potential to be Affected</u></p> <p>On 3/18/14, the Maintenance Director inspected other designated smoking</p>		

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K 066	Continued From page 3 containers with self-closing lids to all smoking areas for ashtrays to be emptied into. The facility has 3 smoking areas.	K 066	areas and found no other areas to be affected.	3/18/14	
K 130 SS=D	This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on March 10, 2014. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to have fire doors close and latch within their frame. The findings include: Observation on March 10, 2014 at 12:55 p.m. revealed the A Building and B Building separation is with 90 minute fire rated doors. These 90 minute fire rated doors are not provided with latching and panic hardware. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on March 10, 2014. Actual NFPA Standard: NFPA 80 2-1.4 Operation of Doors. All swinging doors shall be closed and latched at the time of fire. For the purposes of this section, the operation of doors is divided into three categories.	K 130	<u>Systematic Changes</u> The Maintenance Director will inspect designated smoking areas monthly to ensure proper placement of self-closing metal ash containers. <u>Monitoring</u> The Maintenance Director will report his findings monthly to the Performance Improvement Committee for review and to determine ongoing compliance. The Performance Committee consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, Maintenance Director, Dietary Manager, Housekeeping /Laundry Director, Activities Director, Medical Records Director, Human Resource Manager, MDS Coordinator, Medical Director, and Consultant Pharmacist. <u>K130</u> Ivy Hall Nursing Home believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions:		

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K 066	Continued From page 3 containers with self-closing lids to all smoking areas for ashtrays to be emptied into. The facility has 3 smoking areas. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on March 10, 2014.	K 066	<u>Corrective Actions for Targeted Area</u> On 3/19/14, the Maintenance Director placed an order with Trimble Door Company for the installation of latching panic hardware on 90-minute fire doors between "A" and "B" buildings.		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to have fire doors close and latch within their frame. The findings include: Observation on March 10, 2014 at 12:55 p.m. revealed the A Building and B Building separation is with 90 minute fire rated doors. These 90 minute fire rated doors are not provided with latching and panic hardware. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on March 10, 2014. Actual NFPA Standard: NFPA 80 2-1.4 Operation of Doors. All swinging doors shall be closed and latched at the time of fire. For the purposes of this section, the operation of doors is divided into three categories.	K 130	<u>Identification of Other Areas with Potential to be Affected</u> On 3/17/14, the Maintenance Director inspected the other fire doors in the facility and found that no other doors were affected. <u>Systematic Changes</u> The Maintenance Director will inspect self-closing doors monthly for proper operation and latching hardware. <u>Monitoring</u> The Maintenance Director will report his findings monthly to the Performance Improvement Committee for review and to determine ongoing compliance. The Performance Committee consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, Maintenance Director, Dietary Manager, Housekeeping /Laundry Director, Activities Director, Medical Records Director, Human Resource Manager, MDS Coordinator, Medical Director, and Consultant Pharmacist.		4/15/14